Supreme Court, U.S.
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No. 00- 848

IN THE

Supreme Court of the United States

JIMMY WALLACE MCNEIL, AS INDEPENDENT EXECUTOR AND REPRESENTATIVE OF THE ESTATE OF MICHAEL JAY MCNEIL,

Petitioner,

v.

TIME INSURANCE COMPANY,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF IN OPPOSITION

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QUESTIONS PRESENTED

1. Whether Title III of the Americans with Disabilities Act (ADA), 42 U.S.C. § 12182, governs the content of group insurance coverage when the same coverage is offered to all persons that apply.

2. Whether ERISA preempts state law claims based on a plan participants right to receive benefits under the ERISA plan.

STATEMENT PURSUANT TO RULE 29.6

Time Insurance Company states that its current name is Fortis Insurance Company (the name change was not the result of a transfer of assets or sale) and is a wholly owned subsidiary of Fortis, Inc., which is a wholly owned subsidiary of (1) Fortis (B) a foreign company that is traded on the Brussels, London and Luxemburg exchanges and (2) Fortis (NV) a foreign company that is traded on the Amsterdam, London and Luxemburg exchanges.

TABLE OF CONTENTS

	Page
Questions Presented	i
Statement Pursuant to Rule 29.6	ii
Table of Contents	iii
Table of Cited Authorities	iv
Statement of the Case	1
A. Factual Background.	1
B. Disposition by the Courts Below.	4
Reasons for Denying the Writ	7
A. The Fifth Circuit's Interpretation of the ADA is Consistent With the Interpretation of Every Other Circuit Court to Consider the Issue.	7
B. The Fifth Circuit's Preemption Analysis Under ERISA is Consistent With This Court's Prior Opinions.	12
Conclusion	16

TABLE OF CITED AUTHORITIES

Page

Cases:

Alexander v. Choate, 469 U.S. 287, 105 S. Ct. 712 (1985) 9

Algren v. Pirelli Armstrong Tire Corp., 197 F.3d 915 (8th Cir. 1999) 13

Bast v. Prudential Ins. Co. of America, 150 F.3d 1003 (9th Cir. 1998) 13

Chabner v. United of Omaha Life Ins. Co., 225 F.3d 1042 (9th Cir. 2000) 7, 8

Doe v. Mutual of Omaha Ins. Co., 179 F.3d 557 (7th Cir. 1999), *cert. denied*, 528 U.S. 1106, 120 S. Ct. 845, 145 L. Ed. 2d 714 (2000) 8, 10, 11, 12

EEOC v. CNA Ins. Co., 96 F.3d 1039 (7th Cir. 1996) 8, 9

Ford v. Schering-Plough Corp., 145 F.3d 601 (3d Cir. 1998), *cert. denied*, 525 U.S. 1092, 119 S. Ct. 850, 142 L. Ed. 2d 704 (1999) 8, 10

Kolasinski v. Cigna Healthplan of CT, Inc., 163 F.3d 149 (2d Cir. 1998) 13

McMahon v. Digital Equipment Corp., 162 F.3d 28 (1st Cir. 1998) 13

Cited Authorities

Page

Modderno v. King, 82 F.3d 1059 (D.C. Cir. 1996), *cert. denied*, 117 S. Ct. 772 (1997) 9

New York Conference of Blue Cross and Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995) 13, 14

Pallozzi v. Allstate Life Insurance Company, 198 F.3d 28 (2d Cir. 2000) 11, 12

Parker v. Metropolitan Life Insurance, 121 F.3d 1006 (6th Cir. 1997), *cert. denied*, 522 U.S. 1084, 118 S. Ct. 871, 139 L. Ed. 2d 768 (1988) 8, 9, 10, 11

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 107 S. Ct. 1549, 95 L. Ed. 2d 39 (1987) 13, 14, 15

Polish Nat. Alliance of the U.S. v. NLRB, 322 U.S. 643, 64 S. Ct. 1196 (1944) 15

Stoutenborough v. NFL, 59 F.3d 580 (6th Cir.) *cert. denied*, 116 S. Ct. 674 (1995) 9

Unum Life Ins. Co. of America v. Ward, 526 U.S. 358 (1999) 14

Weier v. Twentieth Century Fox Film Corp., 198 F.3d 1104 (9th Cir. 2000) 8

White v. Provident Life & Acc. Ins. Co., 115 F.3d 26 (4th Cir. 1997) 13

Cited Authorities

Page

Statutes:

29 U.S.C. § 1002(11) 15

29 U.S.C. § 1002(12) 15

29 U.S.C. § 1144(b)(2)(A) 14

42 U.S.C. § 302(a) 7, 9, 10, 11, 12

42 U.S.C. § 12182 i

Texas Insurance Code Article 21.21 4

Texas Insurance Code Art. 21.21-3 .....5, 7, 12

Texas Insurance Code Art. 21.21-6 5

Texas Insurance Code Art. 21.21 § 4(7)(b) 5, 7, 12

Other Authorities:

28 C.F.R. § 36.307(a) 10

28 C.F.R. § 36.307(c) 10

The Respondent, Time Insurance Company ("Time"), respectfully requests that this Court deny the petition for writ of certiorari seeking review of the Opinion of the United States Court of Appeals for the Fifth Circuit in this case. That opinion is reported at 205 F.3d 179.

STATEMENT OF THE CASE

A. Factual Background.

McNeil was an optometrist who practiced in a partnership called Dickey & McNeil, Optometrists (the "Partnership") which was formed August 29, 1993. App. F2. The Partnership had an employee, its secretary Jana Jay. App. F2. In addition to treating patients, the Partnership also sold glasses to the public, and the glasses sold were shipped to the Partnership from all over the country. *Id.* The Partnership was a member of the Texas Optometric Association (the "Association"). *Id.* One of the benefits of membership in the Association was the ability to purchase group insurance offered to Association members. *Id.*

In April of 1994, McNeil received an informational brochure about health insurance coverage offered by Time to members of the Association. *Id.* The Time coverage was to replace coverage provided to Association members by National American Life Insurance Company of Pennsylvania ("NALICO"). App. F2. The brochure described the policy's benefits and limitations, including a limitation of coverage for acquired immune deficiency syndrome ("AIDS") of $10,000 during the first two years of coverage, and after the first two years, coverage up to the policy maximum of $2,000,000. App. D2.

McNeil, who had NALICO coverage from before the Partnership was formed, decided on behalf of the Partnership to purchase the Time plan to cover himself and the Partnership's employee, Ms. Jay. App. F2-F3. At McNeil's request, the agent soliciting the Time coverage sent McNeil a proposal which reflected that the Time coverage would apply to McNeil and Ms. Jay, that the Partnership had chosen not to provide maternity coverage, and that the premium would be $237 per month for both insureds. App. F3.

After receiving the proposal, McNeil completed the employer application for the Partnership and selected various options relating to the coverage for the employees such as the annual deductible amount, the rate of payment, and whether maternity coverage would be provided. App. F4. The agreement section of the employer application, which appears right above McNeil's signature, states, among other things,

> The employer understands that only full-time employees and their dependents are eligible for coverage. It is agreed that the employer will pay at least the required premium for the employees.

By signing the employer application, McNeil agreed and represented that he had "authority to represent and bind the employer." App. F4.

McNeil and Ms. Jay also mailed to Time employee enrollment forms which stated they were employees of the Partnership. *Id.* In response to medical questions on the enrollment form, McNeil represented that he had not been diagnosed with or treated for AIDS. Ms. Jay and McNeil were eligible for coverage only because they worked for the

Partnership and the Partnership applied for group coverage. App. F3. McNeil's partner, Dr. Dickey, did not enroll since he was covered by Medicare. App. A3.

Time accepted McNeil and Ms. Jay for coverage and certificate booklets evidencing the coverage were sent to the Partnership. App. F4. Time sent monthly premium notices, which always included both Ms. Jay and McNeil, to the Partnership. App. A3. The Partnership always paid the entire premium for Ms. Jay. App. A3. Consistent with the brochure, the certificate booklet set forth that, with respect to AIDS, there was a $10,000 maximum benefit during the first twenty-four months of coverage, and that thereafter the policy maximum would be applicable. App. D3. The certificate also limited benefits for various other conditions including psychiatric/substance abuse, temporomandibular joint dysfunction, and certain transplants. App. D8. The certificate form was approved by the Texas Department of Insurance on August 18, 1992. App. D3.

In September 1994, four months after the Time issued the coverage, McNeil was admitted to the hospital for treatment of an AIDS condition. App. A3. McNeil died on March 1, 1995, after incurring over $400,000 in medical expenses. App. A3. Consistent with the terms of the certificate, Time paid the first $10,000 of McNeil's medical expenses and denied the remaining claims under the terms of the certificate.

B. Disposition by the Courts Below.

Prior to his death, McNeil sued Time in Texas state court.[1] Time removed the case to federal court based upon ERISA preemption and diversity jurisdiction. In his original complaint, McNeil alleged common law causes of action of breach of contract, breach of the duty of good faith and fair dealing, negligent misrepresentations, waiver, estoppel and ratification, along with statutory violations of the Texas Deceptive Trade Practices Act ("DTPA"), Article 21.21 of the Texas Insurance Code and the Texas Commission on Human Rights Act.[2]

On May 10, 1995, Time filed its first motion for summary judgment arguing that McNeil's claims were preempted by ERISA and the Texas Commission on Human Rights Act claim was otherwise barred. On May 15, 1995, McNeil filed his first amended complaint which retained the same claims as the original complaint but added a claim under the ADA and an alternative claim for relief under ERISA. On May 30, 1995, Time filed a supplemental motion for summary judgment which addressed McNeil's claim under the ADA. Rather than rule on these pending motions, the Trial Court granted McNeil ninety days to conduct discovery on the ERISA issue and thereafter file responses to the pending motions for summary judgment.

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1. The executor of McNeil's estate substituted in as plaintiff after McNeil's death. Throughout this brief, however, "McNeil" will refer to both McNeil and his estate.

2. McNeil did not appeal to the Fifth Circuit the Trial Court's dismissal of his claim under the Texas Commission on Human Rights Act and does not complain about the disposition of that claim in his Petition herein.

After discovery, Time filed its second supplemental motion for summary judgment on January 9, 1996, again arguing that ERISA governed the case and including additional facts obtained during discovery. On the same date, McNeil filed his response to the motion for summary judgment relating to the applicability of the ADA. On January 30, 1996, McNeil filed a second amended complaint that added no new causes of action but merely clarified prior allegations. On March 1,1996, Time filed its second motion for summary judgment arguing that the limitation of coverage for AIDS did not violate Texas law or ERISA. In response, McNeil argued that the limitation of coverage violated Texas Insurance Code Art. 21.21-3, Art. 21.21-6, and Art. 21.21 § 4(7)(b). McNeil also argued that the certificate was ambiguous and violated the ADA, and the limitation was therefore unenforceable.

On August 28, 1996, the Trial Court issued it memorandum order (1) granting Time summary judgment on McNeil's ADA claim and (2) denying Time summary judgment on ERISA. App. B. On April 3, 1997, the Trial Court issued its memorandum opinion granting Time's second motion for summary judgment, upholding the validity and enforceability under Texas law of the limitation on benefits for AIDS. App. D. After this ruling, McNeil filed a motion for reconsideration, which the Trial Court denied on June 12, 1997. App. E.

On June 24, 1997, the Trial Court held a bench trial limited solely to the question of whether an ERISA plan existed and therefore McNeil's remaining state law claims were preempted. On August 18, 1997, after the trial on the ERISA issue, McNeil filed his third amended complaint, which did not add any causes of action, but rather alleged

that several of the causes of action previously pled were supported by the factual allegation that the limitation of benefits for AIDS was "without a sound actuarial basis or actual or reasonably anticipated loss experience".

On September 2, 1997, Time filed a motion to dismiss the claims in the third amended complaint that were based upon an alleged failure to follow sound actuarial principles, arguing that (1) there was no support in Texas law for the claim, (2) the Trial Court had previously held that the limitation was enforceable under Texas law and the allegation was therefore untimely, and (3) the claim was preempted by ERISA since the actuarial claim was alleged within the rubric of causes of action that were preempted by ERISA.

On September 10, 1997, the Trial Court issued its memorandum order determining that ERISA governed the case and preempted McNeil's remaining state law claims. App. F. On the same date, the Trial Court dismissed all of McNeil's claims, other than claims under ERISA, with prejudice. App. G1. Nevertheless, the parties continued to brief the issue of whether McNeil's new factual allegation regarding actuarial soundness supported the causes of action pled. Indeed, in a joint status report filed by the parties on September 24, 1997, the parties listed various motions as pending, including Time's motion to dismiss claims based on alleged failure to follow sound actuarial principles.

On December 18, 1997, the Trial Court granted Time's motion to dismiss the actuarial claims and denied McNeil's motion for new trial and/or to amend or alter the September 10, 1997 order. App. I. On April 21, 1998, the parties filed an agreed motion to dismiss and request for entry of final judgment. Pursuant to the agreed motion, on April 23, 1998,

the Trial Court dismissed with prejudice McNeil's remaining claim for damages under ERISA and entered a final judgment that McNeil take nothing against Time. App. J.

McNeil appealed several of the Trial Court's rulings to the Fifth Circuit Court of Appeals. In addressing McNeil's complaints, the Fifth Circuit held that Time did not violate Texas Insurance Code Article 21.21-3 or Article 21.21.-4(7)(b). While questioning whether McNeil had stated a valid claim for failure to follow actuarial principles, the Fifth Circuit held that all the remaining claims were preempted since the claims were premised on an alleged failure to pay benefits under an ERISA plan. Finally, the Fifth Circuit held that Time did not violate the ADA since that statute does not govern the substantive terms of insurance policies when the same policy is issued to all applicants regardless of disability status.

REASONS FOR DENYING THE WRIT

A. The Fifth Circuit's Interpretation of the ADA is Consistent With the Interpretation of Every Other Circuit Court to Consider the Issue.

The issue presented is whether Title III of the ADA governs the content of insurance coverage when the same coverage is offered to all persons that apply. The import of Petitioner's argument is that Title III of the ADA prohibits "discrimination" in the content and design of goods and services offered by places of public accommodation, including the content and design of group insurance products purchased by employers. However, every Circuit Court that has ruled on this issue has ruled consistently with the Fifth Circuit that Title III of the ADA is inapplicable. *See Chabner*

v. United of Omaha Life Ins. Co., 225 F.3d 1042 (9th Cir. 2000); *Weier v. Twentieth Century Fox Film Corp.*, 198 F.3d 1104 (9th Cir. 2000); *Doe v. Mutual of Omaha Ins. Co.*, 179 F.3d 557 (7th Cir. 1999), *cert. denied*, 528 U.S. 1106, 120 S. Ct. 845, 145 L. Ed. 2d 714 (2000); *Parker v. Metropolitan Life Insurance*, 121 F.3d 1006 (6th Cir. 1997), *cert. denied*, 522 U.S. 1084, 118 S. Ct. 871, 139 L. Ed. 2d 768 (1988); *Ford v. Schering-Plough Corp.*, 145 F.3d 601 (3d Cir. 1998), *cert. denied*, 525 U.S. 1092, 119 S. Ct. 850, 142 L. Ed. 2d 704 (1999). In *Doe*, a case virtually identical to this one, the Seventh Circuit held consistently with the Fifth Circuit that:

> Section 302(a) does not require a seller to alter his product to make it equally valuable to the disabled and to the non-disabled, even if the product is insurance.

Doe, 179 F.3d at 563. The Seventh Circuit went on to note that its "conclusion is consistent with all the appellate cases to consider this or cognate issues." *Id.* (citations omitted). Importantly, this Court declined to review *Doe*.

The Fifth Circuit's holding is also consistent with pronouncements by this Court and other Circuit Courts that a uniformly applied limitation of benefits is not discriminatory. In the present case, the evidence is uncontroverted that Time provided the same coverage to all those who were eligible, including McNeil. In a similar context, the court in *EEOC v. CNA Ins. Co.*, 96 F.3d 1039 (7th Cir. 1996) stated:

> There is no claim here that CNA discriminated on the basis of disability in offering its Pension Plan to anyone. It did not charge higher prices to

> disabled people, on the theory that they might require more benefits. Nor did it vary the terms of its Plan depending on whether or not the employee was disabled. All employees — the perfectly healthy, the physically disabled, and the mentally disabled — had a Plan that promised them long-term benefits from the outset of disability until age 65 if their problem was physical, and long-term benefits for two years if the problem was mental or nervous. This may or may not be an enlightened way to do things, but it is not discriminatory in the usual sense of the term.

Id at 1044. (addressing a claim under Title I of the ADA) (citation omitted). *See also Alexander v. Choate*, 469 U.S. 287, 105 S. Ct. 712 (1985) (decided under the Rehabilitation Act); *Parker* 121 F.3d at 1015-19; *Stoutenborough v. NFL*, 59 F.3d 580 (6th Cir.) *cert. denied*, 116 S. Ct. 674 (1995); *Modderno v. King*, 82 F.3d 1059 (D.C. Cir. 1996), *cert. denied*, 117 S. Ct. 772 (1997). As noted in *Modderno*, "as long as the [benefit plan] offers the same coverage to all insureds, regardless of disability, it cannot be said to discriminate on the basis of disability." *Modderno*, 82 F.3d at 1066 (Judge Ginsberg concurring). Here, Time offered the same coverage to everyone, and therefore its conduct is not discriminatory "in the usual sense of the term." *CNA*, 96 F.3d at 1044.

The Fifth Circuit's holding is similarly consistent with regulations, applicable to all businesses, promulgated under Title III, which provide:

> This part does not require a public accommodation to alter its inventory to include accessible or

> specialty goods that are designed for, or facilitate use by, individuals with disabilities.

28 C.F.R. § 36.307(a). Thus, Title III does not require all American businesses that are considered "public accommodations" to enter specialty markets. *See* 28 C.F.R. § 36.307(c). Similarly, consistent with the decisions of every Circuit Court to address the issue, Title III cannot reasonably be interpreted to require health insurers to fund all range of potential insureds' risks, particularly when the same coverage is issued to all who apply. Indeed, to adopt McNeil's proposed interpretation would convert Title III of the ADA from a guaranty of access to a mandated benefits provision in relation to the insurance industry. The effect of McNeil's proposed interpretation is that an insurance company would be required to provide coverage for every condition that could potentially be disabling. As determined by every Circuit Court to address the issue, the ADA simply does not mandate such a result.[3]

Further, in refusing to follow the Department of Justice's administrative pronouncements interpreting the ADA to apply to the content of insurance policies, the Fifth Circuit followed the lead of the Seventh, Sixth, and Third Circuits, which also rejected the DOJ's interpretation because it conflicted with the express language of the ADA. *See Doe*, 179 F.3d at 562-63; *Ford*, 145 F.3d at 613 ("[the DOJ's] interpretation is 'manifestly contrary' to the plain meaning of Title III and,

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3. Such a result would also disrupt the expectations of the parties since insurance products are priced, on a class basis, envisioning coverage for only the specific risks set out in the policy. Requiring additional coverage to already issued policies would force a complete repricing of the coverage for all insureds.

accordingly, is not binding on this Court"); *Parker*, 121 F.3d at 1012 n.5 ("As [the DOJ's] interpretation is inconsistent with its regulations and the statutory text of Title IV, we decline to adopt it"). The Fifth Circuit's Opinion in this case, holding that Title III does not govern the content and design of insurance policies, as well as the content and design of other goods offered for sale by places of public accommodation, is consistent with the holdings of the other Circuit Courts to address the issue.

McNeil concedes (Petition, p. 9) that the decision below is consistent with the decisions of the Third, Sixth, Seventh, and Ninth Circuits. He argues, however, that it is inconsistent with the standard adopted in *Pallozzi v. Allstate Life Ins. Co.*, 198 F.3d 28 (2d Cir. 2000). But in *Pallozzi*, the issue presented in this case was never even addressed.[4] In this regard, *Pallozzi* involved an insurance company that had refused to sell a life insurance policy, without explanation, to a disabled individual. In concluding that Title III could apply to a refusal to sell insurance to a disabled individual, the Second Circuit did not have occasion to decide whether Title III regulated the content of the insurance to be sold. Indeed, the Second Circuit relied, at least in part, on the Seventh Circuit's opinion in *Doe*, which specifically held, on facts virtually identical to this case, that Title III does not regulate the content and design of insurance policies. *Pallozzi*, 198 F.3d at 33. The Second Circuit summarized its holding by stating:

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4. Time respectfully disagrees with the Fifth Circuit's statement that "the Second Circuit read Title III to regulate content as well as access." App. A14. As set forth herein, *Pallozzi* dealt strictly with access to insurance. In the Fifth Circuit's defense, *Pallozzi* was decided after briefing had closed in this case, and therefore Time did not address this distinction in its brief.

> We believe an entity covered by Title III is not only obligated by the statute to provide disabled persons with physical access, but is also prohibited from refusing to sell them its merchandise by reason of discrimination against their disability.

Id. citing Doe v. Mutual of Omaha, 179 F.3d at 559, 564. The Second Circuit did not hold that the ADA controlled the terms of the policy to be sold. While McNeil alleges disagreement among the district courts on this issue, resolving disagreements among district courts is the function of the Courts of Appeals, not this Court. Since there is no conflict among the Circuit Courts on the issue of whether Title III governs the content and design of insurance policies when the same coverage is offered to all, certiorari should be denied.

B. The Fifth Circuit's Preemption Analysis Under ERISA is Consistent With This Court's Prior Opinions.

McNeil argues that the state law claims he asserted are not preempted by ERISA. However, McNeil curiously fails to identify the claims he is referencing. As noted above, his claim under Texas Insurance Code Art. 21.21-3 and Art. 21.21 § 4(7)(b) were addressed on the merits. Further, the Fifth Circuit, in addressing McNeil's claim that the policy failed to follow sound actuarial principles, specifically determined that the Texas Administrative Code provisions relied on by McNeil "do not provide the foundation for a claim." *See* App. A20 n.21. As noted by the Fifth Circuit, the claims that were not addressed on the merits and were found to be preempted were: breach of contract, breach of the duty of good faith

and fair dealing, negligent misrepresentation, common law discrimination, waiver, estoppel and ratification, and his claim that various provisions of the Texas Insurance Code requiring sound actuarial principles are incorporated into state contract law and tort law (under the duty of good faith and fair dealing) when insurance is involved. *See* App. A20. Further, the foundation of all of these claims was McNeil's right to receive benefits under an ERISA plan. *See* App. A21.

Consistent with this Court's prior guidance, the Fifth Circuit preempted the claims because they were based on McNeil's right to receive benefits under the terms of an ERISA plan. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 107 S. Ct. 1549, 95 L. Ed. 2d 39 (1987). McNeil does not argue that another Circuit Court has concluded that preemption is not warranted under these circumstances since the Circuit Courts are in agreement in this issues. *See, e.g.*, *Algren v. Pirelli Armstrong Tire Corp.*, 197 F.3d 915 (8th Cir. 1999) (estoppel claim preempted by ERISA); *Kolasinski v. Cigna Healthplan of CT, Inc.*, 163 F.3d 149 (2d Cir. 1998) (breach of contract and unfair trade practices claims arising out of failure to pay benefits are preempted by ERISA); *McMahon v. Digital Equipment Corp.*, 162 F.3d 28 (1st Cir. 1998) (claims for breach of contract, negligent administration, and unfair trade practices are preempted by ERISA); *Bast v. Prudential Ins. Co. of America*, 150 F.3d 1003 (9th Cir. 1998) (Washington Insurance Code and Washington Consumer Protection Act claims, as well as claims for breach of contract and negligence, preempted); *White v. Provident Life & Acc. Ins. Co.*, 115 F.3d 26 (4th Cir. 1997) (waiver and estoppel claims preempted by ERISA). Nor does McNeil explain how the analysis regarding ERISA preemption in relation to his specific claims is somehow altered by *New York Conference of Blue Cross and Blue*

Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995). McNeil is, in reality, arguing for a reassessment of all preemption analysis under ERISA going back to *Pilot Life*. Time submits that such a reassessment is not only unwarranted, but is inappropriate given the specific claims asserted by McNeil that were determined to be preempted by the Fifth Circuit in this case.[5]

Although McNeil argues that the decision below misinterpreted *Travelers* and *Unum Life Ins. Co. of America v. Ward*, 526 U.S. 358 (1999), he points to no decision of any Court of Appeals holding similar claims not to be preempted. In fact, there are none. At most, McNeil argues that *Travelers* and *Unum* were incorrectly applied to the facts of this case. Such a fact bound claim does not warrant this Court's review.

Similarly, McNeil's argument that the Fifth Circuit misapplied the ERISA Savings Clause, 29 U.S.C. § 1144(b)(2)(A), at best overstates his case. In this regard, McNeil argues that "each of the laws relied upon," both statutory and common law, are saved from preemption. *See* Petition, p.19. However, each of McNeil's claims based on Texas Insurance Code provisions and regulations were disposed of by the Fifth Circuit on the merits. This is not surprising since the Trial Court also addressed these claims on the merits. Specifically, prior of the Trial Court holding that ERISA was applicable to the case, it had already ruled that the limitations on benefits for AIDS was valid and

5. Time would note that the claims have questionable viability regardless of preemption. The Fifth Circuit determined that the limitation on coverage, which formed the basis of Time's denial of benefits, was valid and enforceable, and McNeil's claims were predicated on a wrongful failure to pay benefits.

enforceable under Texas law, despite the statutory and common law claims asserted by McNeil. *See* App. D1. Since the Trial Court addressed such claims on the merits, the Fifth Circuit did so as well. *See* App. A4, n.1. Once the Fifth Circuit determined, as did the Trial Court, that the limitation on benefits was valid and enforceable under Texas law, the only remaining issue, as explicitly recognized by the Fifth Circuit, was McNeil's "right to receive benefits under the terms of an ERISA plan." App. A21. Under this Court's holding in *Pilot Life* such claims are not saved from preemption, particularly given "congressional intent that ERISA's civil enforcement scheme be exclusive." *Pilot Life*, 107 S. Ct. at 1555-1558.[6]

Finally, McNeil asserts that the Fifth Circuit employed an overbroad definition of interstate commerce in determining that ERISA was applicable. The Fifth Circuit's analysis is consistent with the terms of ERISA and this Court's prior pronouncements. This Court has long recognized that the use of the term "activity affecting commerce" manifests a congressional intent to regulate "within the full sweep of its constitutional authority." *Polish Nat. Alliance of the U.S. v. NLRB*, 322 U.S. 643, 647, 64 S. Ct. 1196, 1198 (1944). Since the evidence established that the Partnership sold goods, such as glasses, which were shipped to the Partnership from all over the Country, it was engaged in interstate commerce sufficient to bring the plan squarely within the parameters of ERISA. *See* 29 U.S.C. § 1002(11) and (12). This fact bound determination does not warrant review by this Court.

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6. McNeil asserts that the Court's disposition in *Egelhoft*, No. 99-1529, could somehow effect this case. However, *Egelhoft* does not involve ERISA's civil enforcement scheme and therefore, would not effect the Fifth Circuit's decision in this case.

CONCLUSION

For the reasons stated, the petition for the writ of certiorari should be denied.

Respectfully submitted,

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